COMPLIANCE PEER REVIEW

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER AND CLINIC

Prepared by:

California Department of Corrections and Rehabilitation
Office of Audits and Compliance

Preliminary Report

July 2008

STUDENT ENROLLMENT

Division of Juvenile Justice Education Manual, Sections 4065-4067, and Subsection of the California Education Authority, Section III (b)

Office of Audits and Compliance Staff
Eric Fransham, Parole Agent III
Nick Martinez, Assistant Principal

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EXECUTIVE SUMMARY

The Office of Audits and Compliance, Compliance/Peer Review Branch (CPRB) reviewed the Division of Juvenile Justice (DJJ) Education Manual, Sections 4065-4067, and sub-sections of the California Education Authority (CEA), Section III (b), to determine whether Jack B. Clarke High School (JBCHS) at the Southern Youth Correctional Reception Center and Clinic (SYCRCC) is in compliance with the policies stating that students are to be enrolled into an appropriate educational program within four days of arrival to his/her assigned facility.

The review period was July 14, 2007 through July 18, 2008. During this period, it was determined that JBCHS had a total of 125 wards that did not have their high school diploma or their General Education Certificate. There were four categories of students sampled; General Education, English Language Learner, Special Education, and Special Education/English Language Learner. The CPRB reviewed 25 student records from the Ward Information Network; an approximate sample size of 20 percent. From the English Language Learner category, eight records were reviewed. In the Special Education category, five records were reviewed. From the Special Education/English Language Learner category, six records were reviewed. From the General Education category, six records were reviewed.

The principal and the primary school scheduler were interviewed to gain an understanding of the student enrollment process.

The CPRB determined that JBCHS is not in compliance with the CEA, Section III (b), and the DJJ Education Manual, Sections 4065-4067. The findings are as follows:

- English Learner/Special Education student not enrolled within four days.
- General Education student not enrolled within four days.
- Inadequate operational procedures on student enrollment policy.

BACKGROUND

The CPRB met with the Supervisor of Correctional Education Programs for the Division of Juvenile Justice Education Department (DJJED) on December 20, 2007. The purpose of the meeting and subsequent meetings with the DJJED was to discuss the peer review process, to identify high risk areas, and decide on the highest risk areas to be evaluated during the peer review. Based on risk factor, it was determined that student enrollment within four days of arrival to his/her assigned facility would be reviewed.

Student enrollment was selected for review because students that are not high school graduates are mandated to be enrolled in school per the DJJ Educational Manual, Sections 4065-4067, and the CEA, Section III (b). Additionally, student enrollment within four days of arrival has been a problem area for DJJ schools in the past.

The specific objectives of the review were to determine whether:

- JBCHS is enrolling students into classes within four days of arrival to his/her assigned facility.

- JBCHS has a written educational operating policy to address student enrollment within four days of arrival to his/her assigned facility.

FINDINGS AND RECOMMENDATIONS

Finding I: English Learner/Special Education student not assigned to school within four days of arrival.

One out of six (17 percent) English Learner/Special Education students was not enrolled into an appropriate educational program within four school days of arrival to the facility.

The student was not enrolled into school within four days of arrival because the student transferred directly into SYCRCC's general population. The student was already committed to DJJ, and was transferred to SYCRCC from another facility. Thus, the student did not go through the clinic process as a new commitment to DJJ.

Criteria:

CEA Education Services Branch, Section III (b), states the following: "As students arrive at CEA high schools, they are assessed and enrolled into appropriate educational programs within four school days of their arrival."

Recommendation:

Develop a monitoring system to accurately ensure students are enrolled into school within four days of arrival.

Develop a written procedure to ensure that students are assigned to an appropriate educational program within four days of arrival to their assigned facility.

Finding II: General Education student not assigned to school within four days of arrival.

One out of six (17 percent) General Education students was not enrolled into an appropriate educational program within four school days of arrival to the facility.

The student was not enrolled into school within four days of arrival because the student transferred directly into SYCRCC's general population. The student was already committed to DJJ and was transferred to SYCRCC from another facility. Thus, the student did not go through the clinic process as a new commitment to DJJ.

Criteria:

CEA Education Services Branch, Section III (b), states the following: "As students arrive at CEA high schools, they are assessed and enrolled into appropriate educational programs within four school days of their arrival."

Recommendation:

Develop a monitoring system to accurately ensure students are enrolled into school within four days of arrival.

Develop a written procedure to ensure that students are assigned to an appropriate educational program within four days of arrival to their assigned facility.

Finding III: Inadequate operational procedures on four day student enrollment policy.

The enrollment procedures that were developed by the school scheduler were not signed by the Principal. The enrollment procedures were written in a memorandum from the school scheduler. No formal training was implemented based on the information in the memorandum.

Criteria:

DJJ Education Manual, Sections 4065-4067, states in part: "The Principal shall: Have a written procedure in place to ensure students are assigned to the appropriate education program based on their High School Graduation Plan, (YA) DJJ 7,423, and/or Personal Education Plan, DJJ 7.102, and their need for supplementary services within four school days of arrival to his/her assigned facility…"

Recommendation:

Develop a local operating procedure for student enrollment that has a date and a signature block for the Principal.

Send out a copy of the local student enrollment operating procedure to educational staff that are directly responsible for enrolling students within four days of arrival.

Provide training on the local student enrollment operating procedure to educational staff that are responsible for student enrollment.

Place a copy of the employee's training record in their training file.

Review of Student Enrollment

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER AND CLINIC

GLOSSARY

CEA	California Education Authority
CPRB	Compliance/Peer Review Branch
DJJ	Division of Juvenile Justice
DJJED	Division of Juvenile Justice Education Department
JBCHS	Jack B. Clarke High School
SYCRCC	Southern Youth Correctional Reception Center and Clinic

COMPLIANCE PEER REVIEW

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER AND CLINIC

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California Department of Corrections and Rehabilitation
Office of Audits and Compliance

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HEALTH CARE SERVICES REQUEST FORMS

Institutions and Camps Manual, Sections 6169, 6255, and Revision IT-46, Section 6249.9.

Office of Audits and Compliance Staff
Karen Jennings, Treatment Team Supervisor
Ji Hong Kim Psy.D, Senior Psychologist, Supervisor

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EXECUTIVE SUMMARY

The Office of Audits and Compliance, Compliance/Peer Review Branch (CPRB) reviewed the Institution and Camps Branch Manual (I&C Manual), Sections 6169, 6255, and Revision IT-46, Section 6249.9 to determine whether Southern Youth Correctional Reception Center and Clinic (SYCRCC) is in compliance with the policies that identify the responsibilities of health care staff for treating, evaluating, and tracking wards that request mental health services by submitting a Health Care Services Request form, Division of Juvenile Justice (DJJ) 8.018.

The review period was December 1, 2007 through May 31, 2008. During this period, the CPRB reviewed the Health Care Services Request Tracking log and found a total of 61 Health Care Services Requests submitted by wards in need of mental health services. Due to the low number of requests, the CPRB reviewed 10 records to obtain an accurate assessment. Therefore, 10 wards and their Unified Health Records (UHR) were selected for review. Of the 10 wards selected, 4 submitted multiple requests. As a result 10 UHRs, and 17 Health Care Services Request forms were reviewed.

The CPRB determined that SYCRCC is not in compliance with the I&C Manual, Sections 6169, 6255, and Revision IT-46, Section 6249.9. The findings are as follows:

- Missing Health Care Services Request forms;
- Lack of documentation;
- Psychologist's documentation not in the UHR;
- Health Care Services Request forms not properly completed; and
- One Health Care Services Request form not entered on the Health Care Services Request Tracking log.

BACKGROUND

In December 2005, an audit report was prepared by the Office of the Inspector General (OIG) documenting a ward's request for mental health services through the Health Care Services Request form. On four different occasions while assigned to Preston Youth Correctional Facility (PYCF), a ward requested mental health services. The ward's requests began in October 2004 and concluded in December 2004. Despite numerous requests, the ward never received treatment. One of the requests contained documentation by staff that the ward did not want to be seen. Follow-up was not indicated by a psychologist or psychiatrist.

In March 2005, the ward was transferred to N. A. Chaderjian Youth Correctional Facility (NACYCF). There was no indication in the UHR that the ward requested mental health services on four separate occasions. The ward was classified as a low suicide risk. The ward was assigned to an intake hall and eventually transferred to a general population hall. The ward did not receive proper intervention from his earlier requests, while assigned to PYCF.

While the ward was assigned to NACYCF, there was no documentation that the ward continued to request mental health intervention. In July 2005, the ward's hall went on lock down due to a serious staff assault. In August 2005, the ward successfully committed suicide.

As a result, the CPRB determined that the procedures for requesting mental health intervention by way of the Health Care Services Request form should be reviewed. The review will help to ensure that all wards who request mental health services by submitting a Health Care Services Request form will receive treatment and the intervention will be documented.

The specific objectives of the review were to determine whether:

- The Health Care Services Request forms are being processed according to the I&C Manual, Revision IT-46, Sections 6169, and 6255;
- Health Care staff is collecting the Health Care Services Request forms daily;
- Health Care Services Request forms are filed in the ward's UHR;
- Each form is signed and dated when they are collected, and entered on the Health Care Services Request Tracking log, DJJ 8.017; and
- The Registered Nurse (RN) reviews all requests including signing, dating, and placing the time in the designated areas.

The RN is prioritizing the requests by the following methods:

- Urgent requests shall be seen the day of the request;
- Routine requests shall be seen within one business day of the request; and
- Requests for mental health care may be referred to mental health services, if available within the time limits of urgent or routine priority.

Weekends and Holidays

- The health care staff is delivering all forms to the Outpatient Housing Unit (OHU) RN or designee on weekends and holidays after entering the form on the Health Care Services Request Tracking Log.

The OHU RN or designee shall:

- Review the form for mental health needs and establish priorities for each request on an urgent or routine basis;
- Sign, date, and time stamp the forms in the designated areas;
- Determine whether urgent conditions relating to mental health should be reported to the appropriate on site psychiatrist;
- The night before the next scheduled clinic, all routine requests shall be returned to the appropriate medical clinic for scheduling and to the appropriate mental health staff member for collection;
- Psychologists/Psychiatrists are providing treatment to the wards making the requests. (Revision IT-46, Section 6249.9);
- Psychologists/Psychiatrists are placing documentation in the UHR that appropriate care has been delivered. (I&C Manual, Section 6255); and
- Psychologists/Psychiatrists are completing a brief note including the date, signature, and time stamp in the Chronological Record of Medical Care using the Subjective Objective Assessment Plan (SOAP) format. (I&C Manual, Section 6169 and 6255.)

The CPRB determined whether the objectives were met by reviewing:

- The I&C Manual, Sections 6169 and 6255, Revision IT-46; Temporary Departmental Orders; and the facilities operational manuals.
- The audit report prepared by the OIG; Special Review into the Death of a Ward on August 31, 2005 at NACYCF, December 2005;

- Health Care Services Request forms relating to mental health;
- Health Care Services Request Tracking logs during the period of December 1, 2007 through May 31, 2008;
- UHRs;
- Information obtained from interviews with health care staff members; and
- The Ward Information Network (WIN) system data.

FINDINGS AND RECOMMENDATIONS

Finding I: Missing Health Care Services Request forms.

Of the 17 Health Care Services Request forms in the sample, 4 (24 percent) were not in the UHRs. As a result, only 13 Health Care Services Request forms could be reviewed.

The CPRB determined that the RN triages the Health Care Services Request forms pertaining to mental health. Subsequently, the Health Care Services Request form is given to the Mental Health Secretary. Once the Mental Health Secretary receives the form, it is placed in various psychologists' mailboxes. The ward is then scheduled for an appointment with the psychiatrist. The reason for the missing or lost Health Care Services Request forms is due to the lack of a tracking system.

Criteria:

Revision IT-46 states: "All Health Care Services Request forms shall be filed in the UHR."

Recommendations:

Develop a standardized area in the UHR where the Health Care Services Request form is to be filed.

Provide formal training to Health Care Staff regarding the proper filing of Health Care Services Request forms.

Develop a monitoring system to track all Health Care Services Request forms that pertain to Mental Health.

Finding II: Lack of documentation.

Of the 17 Health Care Services Request forms submitted for mental health services, there was no documentation in the UHR or WIN that 9 (53 percent) of the requests were evaluated by the psychiatrist/psychologist.

The CPRB reviewed the Mental Health section of the UHR and the WIN system to verify that the wards received treatment by the psychiatrist/psychologist. As a result, the CPRB could not locate any documentation that the 9 requests were evaluated by the psychiatrist/psychologist.

The CPRB determined the lack of documentation is contributed to the psychiatrist/psychologist not being properly trained on how to document the evaluation of wards who request mental health treatment by submitting a Health Care Services Request form.

Criteria:

I&C Manual, Section 6255, states: "The UHR is the official and chronological record of mental health treatment. The UHR shall be used as the primary record to document that appropriate care has been delivered."

- Clinical health services staff shall complete a brief note including the date, signature, and time stamp in the Chronological Record of Medical Care that draws attention to the filed document;
- Record changes in a ward's behavior, mental health status, mental health treatment, or program design in a timely fashion;
- Describe the problem and/or present event, observations, clinical assessment, planned care, and anticipated results;
- Use the SOAP format for recording, as outlined in the I&C Manual, Section 6169, UHR;
- Record summaries of individual interactions, group mental health interactions, and program progress; and
- Note the date and time of all UHR entries and sign above a printed name stamp.

Recommendation:

Provide formal training to all psychiatrists/psychologists on the proper method for documenting that care has been delivered.

Finding III: Psychologist's documentation not in the UHR.

During the review, the CPRB attempted to locate 17 records of documentation from the psychiatrist/psychologist. However, the CPRB only found 8 records of documentation of mental health services provided to wards.

Of the eight records of documentation that services were provided to wards, one (13 percent) was not in the UHR.

The CPRB did not find a printed copy of the Chronological Record of Medical Care that documented the ward's mental health treatment regarding his Health Care Services Request form in the UHR. The CPRB found the missing UHR documentation in the WIN system.

The CPRB determined the lack of documentation in the UHR is due to the printed copy of the Chronological Record of Medical Care being lost or not initially printed.

Criteria:

I&C Manual, Section 6255, states: "The UHR is the official and chronological record of mental health treatment. The UHR shall be used as the primary record to document that appropriate care has been delivered."

- Clinical health services staff shall complete a brief note including the date, signature, and time stamp in the Chronological Record of Medical Care that draws attention to the filed document;
- Record changes in a ward's behavior, mental health status, mental health treatment, or program design in a timely fashion;
- Describe the problem and/or the present event, observations, clinical assessment, planned care, and anticipated results;
- Use the SOAP format for recording, as outlined in the I&C Manual, Section 6169, UHR;
- Record summaries of individual interactions, group mental health interactions, and program progress; and
- Note the date and time of all UHR entries and sign above a printed name stamp.

Recommendation:

Provide training to Mental Health Professionals on the requirements for documentation.

Finalize the Draft Local Operating policy.

Develop a monitoring system to ensure the assessments are documented and placed in the UHRs.

Finding IV: Health Care Services Request forms not properly completed.

The RN did not establish a priority level on 9 of the 13 (69 percent) forms reviewed. The RN did not complete the lower portion of the Health Care Services Request form that addresses establishing a priority level.

The RN did not review, sign or enter the date and time on 8 of 13 (62 percent) Health Care Services request forms reviewed.

The CPRB determined the reason the Health Care Services Request forms are not being properly completed is due to a lack of training; and the RN is not ensuring all required elements are completed on the Health Care Services Request form.

Criteria:

Revision IT-46, states: "All requests shall be reviewed by an RN. The RN shall sign the forms and enter the date and time in the designated area."

The RN shall determine the priority of the request:

- Urgent requests shall be seen on the day of the request;
- Routine requests shall be seen within one business day of the request; and
- Requests for mental health care may be referred to mental health staff if available within the time limits of urgent or routine priority.

Recommendations:

Provide Nurses with assessment training.

Ensure all Health Care Staff follow Revision IT-46.

Finding V: Health Care Services Request form not entered on the Health Care Services Request Tracking log.

A Health Care Services Request form submitted on January 24, 2008, was not entered on the Health Care Services Request Tracking log.

After conducting interviews with staff, the CPRB determined that some of the Health Care Services Request forms are not being logged into the Health Care Services Request Tracking log.

The problem is attributed to staff and wards not following the proper procedure of placing the Health Care Services Request forms in the locked Sick Call box on the living unit. As a result, Health Care Services Request forms are filtering in to Health Care Services through various avenues and the forms are not being logged properly on the Heath Care Services Request Tracking log.

Criteria:

Revision IT-46, states: "Health care staff shall collect the Health Care Services Request forms daily. Each form shall be signed and dated at the time the forms are collected, and entered on Health Care Services Request Tracking Log, DJJ 8.017."

Recommendations:

Ensure all request forms are logged on the Health Care Services Request Tracking log.

Provide training to all staff to ensure awareness that the Health Care Services Request form must be logged by an RN on the Health Care Services Request Tracking Log.

Review of Health Care Services Requests

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER AND CLINIC

GLOSSARY

CPRB	Compliance/Peer Review Branch
DJJ	Division of Juvenile Justice
I&C Manual	Institution and Camps Branch Manual
NACYCF	N. A. Chaderjian Youth Correctional Facility
OHU	Outpatient Housing Unit
OIG	The Office of the Inspector General
PYCF	Preston Youth Correctional Facility
RN	Registered Nurse
SOAP	Subjective Objective Assessment Plan
SYCRCC	Southern Youth Correctional Reception Center and Clinic
UHR	Unified Health Record
WIN	Ward Information Network

Information Security Compliance Review
Exit Conference Discussion Notes
Southern Youth Correctional Reception Center and Clinic
July 14-18, 2008

The Office of Audits and Compliance (OAC) Information Security Branch (ISB) conducted an Information Security Compliance Review of Southern Youth Correctional Reception Center and Clinic (SYCRCC) between July 14, 2008 and July 18, 2008. The review covered 14 different areas. SYCRCC was fully compliant in 4 areas, partially compliant in 3 areas, and noncompliant in 7 areas. The overall score is 62 percent. The chart below details these outcomes. Other observations, found at the end of this report, are also noted.

FINDINGS SUMMARY:

		Score	Compliant	Partial	Noncompliant
STAFF COMPUTING ENVIRONMENT					
1.	Use Agreement (Form 1857) is on file.	51%			NC
2.	Annual Self-Certification of Information Security Awareness and Confidentiality forms are on file.	74%		PC	
3.	Information Security Training is current.	74%		PC	
4.	Staff can log on using their own password.	100%	C		
5.	Network access authorization is on file.	86%		PC	
6.	Physical locations of CPUs agree to inventory records.	58%			NC
7.	Staff CPUs labeled "No Ward Access."	25%			NC
8.	Staff monitors are not visible to wards.	58%			NC
9.	Anti virus updates are current.	38%			NC
10.	Security patches are current.	0%			NC

WARD COMPUTING ENVIRONMENT (Education, Library, Clerks)					
11.	Physical location of CPUs agrees to inventory records	100%	C		
12.	CPU is labeled as a ward computer.	100%	C		
13.	Anti virus updates are current.	0%			NC
14.	Ward monitors are visible to supervisor.	100%	C		
15.	Portable media is controlled.	NA			
16.	Telecommunications access is restricted.	NA			
17.	Operating system access is restricted.	NA			
18.	Printer access is restricted.	NA			
	Test Totals		4	3	7

Overall Percentage **62%**[1]

[1] Scores for computer-related tests reflect the results of testing on the locatable sample computers only. The institution has not maintained an accurate Information Technology (IT) inventory. Of the 25 staff computers we attempted to locate using the local inventory, there are 10 computers still missing.

OBJECTIVES, SCOPE AND METHODOLOGY

The objectives of the Information Security Compliance Review are to:

- Assess compliance to selected information security requirements.
- Evaluate other conditions discovered during the course of fieldwork that may jeopardize the security of information assets of the facility or of the Department.
- Provide information security training for management and staff.

The ISB did not review any Prison Industry Authority computers.

In conducting the fieldwork, the ISB performs the following:

- Interview members of senior management, information technology staff, institutional staff, and computer users.
- Ask staff to provide evidence that all authorized computer users have Acceptable Use Agreement forms and the appropriate training support documentation on file.
- Tests selected information security attributes of users and IT equipment using three different population samples. This includes both staff and ward computing environments.
- Review various laws, policies, procedures, related to information security in a custody environment.
- Conduct physical inspections of selected computers.
- Observe the activities of the IT support staff.
- Analyze the information gathered through the above processes and formulate conclusions.

FINDINGS AND RECOMMENDATIONS

The ISB provided a copy of our review guide to your IT staff. It contains audit criteria and a detailed methodology. That information, therefore, is not duplicated under each finding.

ISB's findings and recommendations are listed below. ISB staff discussed them with management in an exit conference following our fieldwork. Please contact us if you would like to discuss further, any of these issues.

1. The Internet and Email Policy Compliance Form or CDC Form 1857 are not on file for all computer users. (51 percent compliance.)

Recommendation: Require all staff users to complete CDC Form 1857 before being granted computer access. All Contractors, volunteers, or visitors who use California Department of Corrections and Rehabilitation (CDCR) computers are required to complete an Information Access and Security Agreement Form (CDCR-ISO-1900) before being granted access. (Institution and Camps Branch Manual (I&C Manual), Section1735.)

Best Practice: Required forms can be found on the Information Security Office's Intranet Web site. http://intranet/PED/Information-Security/

2. The Security Awareness Self-Certification and Confidentiality Agreement form is not on file for all computer users. (74 percent compliance.)

Recommendation: Require all computer users to self-certify their information security awareness and confidentiality agreement on an annual basis using form CDCR ISO-3025 or equivalent. (State Administrative Manual (SAM), Section 5300.)

Best Practice: Required forms can be found on the Information Security Office's Intranet Web site. http://intranet/PED/Information-Security/

3. Information Security Training is not current for all computer users. (74 percent compliance.)

Recommendation: Review information security training procedures and training records maintenance. Require that all computer users receive annual information security training. Require appropriate documentation of the training. (SAM, Section 5300.)

Best Practice: The Security Awareness Training material can be found on the Information Security Office's Intranet Web site.
http://intranet/PED/Information-Security/

4. Former employees, and/or contractors, have network access authorization. (86 percent compliance.)

Recommendation: Access to any CDCR computerized information is restricted to authorized persons. The sensitive nature of CDCR data requires strict controls over who is allowed access to it. (I&C Manual, Sections 1720 and 1725.)

Best Practice: Revise the current formal reporting procedure so that all duty changes are reported to the IT Coordinator.

5. The physical locations of staff computers do not agree to inventory records. (58 percent compliance.)

Recommendation #1: Maintain accurate inventory records. Evaluate procedures and resources used to maintain inventory records. (I&C Manual, Section 1720.)

Recommendation #2: The 10 un-locatable staff computers must be found within the 30-day period allowed for developing the corrective action plan. The institution must certify, in writing, that the un-locatable computers were found or properly surveyed out. The list of un-locatable computers is shown below.

Tag/Machine Name	Computer Make/Model
JISYDRAKE-SR	Dell GX270
JISYICP-CONTRO	Dell GX270
JISYMEDICAL1	Dell GX270
JISY-JBCHS-RM6	Dell GX270
JISYSUTTERCONT	Dell GX270
3583	Gateway E-4610S
lanlaptop	Dell GX270
2745	Dell GX270
2895	Dell GX270
3585	Gateway E-4610S

Best Practices: A software solution, such as "i-Inventory," should be considered to meet the needs of IT staff. Local IT staff should maintain a dynamic inventory; updating the inventory each time they relocate or service a computer. The institution should consider using hand held computers (Black Berry or Treo) to access the help ticket system and to post inventory while in the field. (This feature is currently being developed by the Enterprise Information Systems.)

6. Staff monitors and computers are not correctly labeled "No Ward Access." (25 percent compliance.)

Recommendation: Each computer in a facility shall be labeled to indicate whether ward access is authorized. (I&C Manual, Sections 1910 and 5040, and SAM, Section 4840.)

Best Practice: Affix appropriate labels to both the monitor and the CPU.

7. Staff monitors are not visible to wards. (58 percent compliance.)

Recommendation: Reposition staff monitors or use privacy screens to shield monitors from ward view. (SAM, Section 5300.)

8. Staff computers do not have up-to-date antivirus software. (38 percent compliance.)

Recommendation: Update antivirus software on all staff computers. (SAM, Section 4820.)

9. Staff computers do not have up-to-date security patches. (0 percent compliance.)

Recommendation: Update security patches on all staff computers. (SAM, Section 4840.)

10. Ward accessed computers do not have up-to-date antivirus software. (0 percent compliance.)

Recommendation: Update antivirus software on all ward computers. (SAM, Section 4841.2.)

OTHER OBSERVATIONS:

Observation 1: Several instances of unattended staff user sessions were observed.

Recommendation: All staff should be reminded of security policy requiring unattended machines to be secured with a password. (SAM, Section 5300.)

Best Practice: Staff should lock computer by using CTL+ALT+DEL and selecting "Lock Computer," or by pressing the Windows Key and L simultaneously.

Observation 2: No clerical assistance for the IT support function.

Best Practice: Clerical could perform non-technical tasks such as maintain the IT equipment and license inventory, prepare and process procurement documents; enter data into work order systems, etc. Redirecting these non-technical tasks to clerical staff would allow technical staff to devote more time to technical duties. Overall, this would result in better utilization of resources.

Observation 3: Ward access to telecommunication devices must be restricted.

Recommendation: Restrict ward access to outside telephone lines, fax machines, and network connections. (I&C Manual, Section 5040, and Youth Authority Manual (YAM), Section 1910.)

Observation 4: Ward computers must have restricted access to the computer operating system and DOS commands.

Recommendation: Configure ward computers so that access is not available to the noted system files. (I&C Manual, Sections 1725 and 5040, and YAM, Section 1910.)

Best Practice: Configure ward computers to allow access to programs and files required by the work or education site only.

Observation 5: All ward accessible printers must have restricted access.

Recommendation: Reports and other printed output from ward-utilized computers shall be reviewed by staff, and appropriate distribution of such output shall be closely monitored. (I&C Manual, Section 5040, and YAM, Section 1910.)

State of California Department of Corrections and Rehabilitation

Memorandum

Date :

To : Cassandra Stansberry
Superintendent
Southern Youth Correctional Reception Center and Clinic

Subject: **PRELIMINARY AUDIT REPORT OF THE PLANT OPERATIONS-SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER AND CLINIC**

Attached is the Preliminary Audit Report of Findings and Recommendations developed during the audit of Plant Operations at Southern Youth Correctional Reception Center and Clinic. The Office of Audits Compliance (OAC), Audits Branch conducted the fieldwork during the period of July 14 through July 18, 2008. A complete description of each finding, its impact, criteria and recommendation is contained within the narrative portion of the report.

There are 14 findings identified in the preliminary report categorized under the topics of Safety and Security, Health and Safety, Fines and Penalties, Late Detection and Additional Workload, and Policies and Procedures.

Please provide, within 45 days, a brief description of your Corrective Action Plan (CAP) for each finding and a date when you expect the finding to be resolved. The OAC will issue a final report within 60 days after receipt of your CAP.

A follow-up audit will be scheduled as deemed necessary. Should you have any specific questions, please contact Michael Robinson at (916) 255-2666. For general information call Patricia Weatherspoon at (916) 255-2729.

RICHARD C. KRUPP, Ph.D.
Assistant Secretary
Office of Audits and Compliance

Attachment

cc: René Francis, OAC
Patricia Weatherspoon, OAC

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION
OFFICE OF AUDITS AND COMPLIANCE

REPORT OF FINDINGS AND RECOMMENDATIONS

BUSINESS SERVICES

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER AND CLINIC

JULY 14 – JULY 18, 2008

PRELIMINARY

CONDUCTED BY

THE AUDITS BRANCH

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OFFICE OF AUDITS AND COMPLIANCE

AUDITS BRANCH

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER AND CLINIC

INTRODUCTION

The California Department of Corrections and Rehabilitation's, Office of Audits and Compliance (OAC), Audits Branch conducted an audit of Business Services at Southern Youth Correctional Reception Center and Clinic (SYCRCC). The purpose of the audit was to analyze and evaluate the level of compliance with State and departmental policies, procedures, rules, regulations, operational objectives, and guidelines. The following areas were audited:

- Safety and Security;
- Health and Safety;
- Penalties and Fines;
- Late Detection and Additional Workload; and
- Policies and Procedures.

The fieldwork was performed during the period of July 14, 2008 through July 18, 2008. The exit conference was held on July 18, 2008.

Michael D. Robinson, Audit Supervisor and Management Auditors, Naomi Banks and Saihra Posas conducted the audit. George Valencia, Youth Authority Administrator I provided second line supervision and review. Richard C. Krupp, Ph.D., Assistant Secretary of OAC provided executive management oversight.

The audit consisted of an entrance conference, test of transactions, interviews, observations, periodic management briefings, an exit conference, and issuance of the preliminary audit report.

OFFICE OF AUDITS AND COMPLIANCE

AUDITS BRANCH

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER AND CLINIC

AUDIT SCOPE

The scope of the audit encompasses the examination and evaluation of the adequacy and effectiveness of SYCRCC's system of management control and compliance to applicable policies, procedures, rules, and regulations. The audit period may include prior fiscal years if deemed necessary. The control objectives include, but are not limited to the following:

- State assets are safeguarded from unauthorized use or disposition;
- Transactions are executed in accordance to management's authorizations;
- Transactions are executed in accordance with applicable rules and regulations;
- Transactions are recorded correctly to permit the preparation of financial and management reports; and
- Programs are working efficiently and effectively.

In order to determine the adequacy of the control systems and level of compliance with State, federal, and departmental procedures, the audit team performed the following audit procedures:

- Examined evidence on a test basis supporting management's assertions;
- Performed detailed analyses of documentation and transactions;
- Interviewed Facility staff;
- Made inspections and observations;
- Performed group discussions of the overall impact of deficiencies; and
- Discussed deficiencies with supervisors and management throughout the audit process.

SYMPTOMS OF CONTROL DEFICIENCIES

Experience has indicated that the existence of one or more of the following danger signals will usually be indicative of a poorly maintained or vulnerable control system. These symptoms may apply to the organization as a whole or to individual units or activities. Department heads and managers should identify and make the necessary corrections when warned by any of the danger signals listed below:

- Policy and procedural or operational manuals are either not currently maintained or are nonexistent;
- Lines of organizational authority and responsibility are not clearly articulated or are nonexistent;
- Financial and operational reporting is not timely and is not used as an effective management tool;
- Line supervisors ignore or do not adequately monitor control compliance;
- No procedures are established to assure that controls in all areas of operation are evaluated on a reasonable and timely basis;
- Internal control weaknesses detected are not acted upon in a timely fashion; and
- Controls and/or control evaluations bear little relationship to organizational exposure to risk of loss or resources.

OFFICE OF AUDITS AND COMPLIANCE

AUDITS BRANCH

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER AND CLINIC

CORRECTIVE ACTION PLAN

SYCRCC's corrective action plan (CAP) is due within 45 days of receipt of the preliminary audit report.

The CAP is designed to document the institution's plan to fully resolve the audit findings. It includes a brief description of the audit finding, the classification of the personnel directly responsible for resolving the finding(s), their telephone number and/or extension, a brief description of the proposed action and the anticipated date of completion.

Please e-mail your completed CAP to George.Valencia@cdcr.ca.gov and Jenee.Gelein2@cdcr.ca.gov. Send the original to George Valencia, P.O. Box 942883, Sacramento, CA 95811-7243.

If you need additional time to prepare your CAP, please contact George Valencia, Youth Administrator at (916) 255-2928.

OFFICE OF AUDITS AND COMPLIANCE

AUDITS BRANCH

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER AND CLINIC

EXECUTIVE SUMMARY

The Audits Branch (AB) conducted an audit of the Business Services Plant Operations at SYCRCC from July 14 through July 18, 2008. The purpose of the audit was to determine the level of compliance with State, federal, and departmental rules, regulations, policies, and procedures.

The exit conference was held on July 18, 2008. The AB requested that SYCRCC provide a CAP within 45 days of receipt of the preliminary audit report.

Areas audited in Plant Operations:

- Safety and Security;
- Health and Safety;
- Fines and Penalties;
- Emergency Equipment;
- Policies and Procedures;

Fourteen findings are identified in the preliminary audit report, categorized under the following topics:

Category	Number of Findings	Page Number
Safety and Security	1	1
Health and Safety	8	1
Fines and Penalties	1	6
Late Detection and Additional Workload	3	7
Policies and Procedures	1	9
Total	**14**	

This executive summary provides the category, a brief description of the finding, criteria, impact, and prior finding, if applicable.

I. SAFETY AND SECURITY

A. Tool Control

Control over tools is inadequate. The AB could not determine which policy to use, the Youth Authority Manual (YAM) 6800 provided by the Chief of Security or the Tool Control Procedure provided by the Chief of Plant Operations I (CPOI) dated May 1993. The AB noted deficiencies in the following areas:

Plumbing Shops:

- Daily Inventories were conducted, completed, and documented for the entire month of July 2008.
- Multiple tools are maintained on the same shadow.
- The AB is unable to reconcile the inventory.

Grounds Shop:

- Staff appeared to be inadequately trained on tool accountability/procedures.

Paint Shop:

- Multiple tools are maintained on the same shadow.
- A Daily Inventory is not conducted and documented on the Daily Inventory Sheet.
- Staff appear to be inadequately trained on tool accountability/procedures.

Impact: These issues may result in late detection of theft and difficulty accounting for tools that have been issued.

II. HEALTH AND SAFETY

A. Health and Safety

There are deficiencies related to the Hazard Communication Program. There is no approved operating procedure regarding, the Control of Dangerous and Toxic Substances. Deficiencies were noted at the following locations: Outside Grounds, Carpenter/Engineer Shop, Plumbing Shop, and the Maintenance Dock Area. Deficiencies were related to the following: Staff appear to be inadequately trained on hazardous communications, chemicals that have out lived their shelf life are maintained without a plan for disposal, the MSDS binder is indexed however it is not updated or user friendly, waste is kept longer than the one-year accumulation period.

Impact: This issue may result in an increased threat to life, health and safety, and gives the appearance that SYCRCC has not implemented and maintained an effective Injury and Illness Prevention Plan (IIPP).

Codes of Safe Practices and Hazard Evaluations are not always developed and updated. Staff is not supplied with access to current hazard information pertinent to their work assignments. For example, a code of safe practices and hazard evaluations has not been developed for Plant Operations (i.e. each specific shop).

Impact: This issue may make training difficult and give the appearance that SYCRCC has not implemented and maintained an effective IIPP.

Plant Operations does not have a written Respiratory Program. In addition, there is not a suitably trained program administrator in accordance with the CCR Title, 8, 5144 and the General Industrial Safety Orders (GISO).

Impact: Division of Juvenile Justice is not maintaining an injury and illness free workplace.

A formalized Confined Space Program has not been established, developed, and implemented. The written program shall be available for inspection by employees and their authorized representatives.

Impact: Employees are at risk of death, incapacitation, and impairment of ability to self-rescue.

The emergency eye wash stations located at the Plant Operations are not maintained appropriately. The AB noticed that the eyewash station logs had not been completed since April 2007.

Impact: These issues may result in an increased threat to life, health, and safety.

There are deficiencies related to the Cross Connection Program (i.e. Backflow devices). Backflow prevention assembly-testers are contracted with Aquatech Backflow Services, Inc., which performs routine Preventive Maintenance (PM) test of backflow devices installed throughout the institution. The AB noted the following deficiencies regarding the cross-connection program: there is no master listing, locations of backflow devices could not be determined, there is no published cross connection schedule for 2008, backflow devices are not tested annually.

Impact: This condition results in difficulty determining whether backflow tests have been performed.

There are deficiencies related to pest/vector control. For example, there are no local operating procedures, insect and rodent activity is prevalent in the main kitchen. Doors and gates are not modified to be vermin proof. This was noted in the Department of Health Services /Environmental Health Survey (DHS/EHS) 2006.

Impact: These conditions show ineffective pest/vector control.

Safety meetings (tailgates) are not conducted for each maintenance section at least every 10 days and written minutes taken. The AB requested and did not receive documented safety meetings (tailgates) in accordance with the §CCR, Title 8.

Impact: Plant operations is not implementing and maintaining an effective IIPP.

III. FINES AND PENALTIES

A. Emergency Generators

Documentation of testing and maintenance of the emergency generators is not in accordance with SYCRCC's maintenance schedule. In addition,

- There are no local procedures establishing standardized procedures and/or direction for the testing and maintenance of emergency generators.
- SYCRCC has completed only 4 of the 14 scheduled maintenance tasks of the calendar year.
- Current operating permits requested were not provided in order to verify if SYCRCC meets the conditions to operate.

Impact: In case of an emergency, the alternate electrical supply may fail. In addition, this condition makes it difficult to determine and validate that emergency generators are tested timely.

IV. LATE DETECTION AND ADDITIONAL WORKLOAD

A. Plant Operations

There are deficiencies related to performing PM. A written PM Plan has not been developed and implemented. The AB could not locate nor was the AB provided historical asset data on the facility's major systems Mechanical and Electrical Equipment.

Impact: These conditions decrease efficiency, increase downtime, and results in additional cost due to repairs.

SYCRCC has not established an approved Operational Procedure (OP) for the work order system (work request and work orders) that affects the entire institution. The local OP should establish guidelines for an orderly and standard method of processing and accomplishing the services requested of the Plant Operations. For example:

- The work order does not contain a date-completed and a completed-by field.
- Supervisors are not approving work orders.
- Parts and materials are not listed on the work orders.
- A priority system has not been established.

Impact: There is no standard method of processing service requests of Plant Operations.

Operational reporting is not used as an effective management tool. Line supervisors do not adequately monitor and act upon weaknesses in a timely manner.

- The total hours used to maintain the physical plant is not documented.
- An operational maintenance report has not been completed or forwarded to management for decision-making.
- Priorities are not established in accordance to departmental guidelines.
- The CPOI or his/her designee does not inspect and document inspections on a regular basis. Examples include a hazard checklist for grounds and a hazard checklist for buildings.
- The CPOI or key plant staff is not assigned to a facility wide committee that has an impact on maintenance and other plant responsibilities such as a space utilization committee.

Impact: This condition may result in inadequate reporting.

V. POLICIES AND PROCEDURES

A. Plant Operations Procedure Manual (POPM)

The POPM is not maintained. For example, the POPM does not promulgate current and/or applicable OP that are relative to the daily operations of Plant Operations activities. The AB noted the following:

- There is no mission statement outlining the goals and objectives of the Plant Operations.
- There are no Tool Control Procedures that have been approved by the superintendent.
- There is no procedure outlining the storage, use, and disposal of toxic materials.
- There is no procedure for lock-out tag-out.
- There is no PM section. Etc…

Impact: There is difficulty in identifying current OP; processes may not be standardized and may result in a vulnerable control system. In addition, lack of policy and procedures may make training difficult.

FINDINGS AND RECOMMENDATIONS

I. SAFETY AND SECURITY

A. Tool Control

Control over tools is inadequate. The AB could not determine which policy to use, the YAM 6800 provided by the Chief of Security or the Tool Control Procedure provided by the CPOI, dated May 1993. The AB noted deficiencies in the following areas:

Plumbing Shops:

- Daily Inventory sheets were conducted, completed, and documented for the entire month of July 2008.
- Multiple tools are maintained on the same shadow.
- The AB is unable to reconcile the inventory.

Grounds Shop:

- Staff appear to be inadequately trained on tool accountability/procedures.

Paint Shop:

- Multiple tools are maintained on the same shadow.
- A Daily Inventory is not conducted and documented on the Daily Inventory Sheet.
- Staff appear to be inadequately trained on tool accountability/procedures.

These issues may result in late detection of theft and difficulty accounting for tools that have been issued.

Institution and Camps Branch Manual (I&C Manual), Section 1821, states: "Each facility shall have a detailed written policy on tool control for all areas of the institution."

CCR, Title 15, Section 3303, states in part: "Institution heads shall maintain procedures for controlling the following safety and security hazards within facilities . . . Control of tools."

Recommendation

Ensure that controls over tools are adequate. Annually review, update, and adhere to the approved Tool Control Procedures.

II. HEALTH AND SAFETY

A. Hazard Communication Program

There are deficiencies related to the Hazard Communication Program. There is no approved OP regarding the Control of Dangerous and Toxic Substances. Deficiencies were noted at the following locations:

Outside Grounds:

- Staff appear to be inadequately trained on hazardous communications.

Carpenter/Engineer Shop:

- A daily perpetual chemical inventory is not conducted.
- Chemicals that have out lived their shelf life are maintained without a plan for disposal.
- The MSDS binder is indexed however it is not updated or user friendly.

Paint shop:

- Hazardous waste labels have two accumulations start dates.
- Hazardous waste is maintained on a wooden pallet versus secondary containment.
- A daily perpetual chemical inventory is not conducted.
- Waste is kept longer than the one-year accumulation period.
- The MSDS binder is not indexed or user friendly.
- The chemical cabinets are not secured.

Plumbing shop:

- A daily perpetual chemical inventory is not conducted.
- There is no hazardous materials cabinet.
- Volatile and toxic substances are maintained on the floor.

Maintenance Dock Area:

- 55-gallon drums of digester and degreaser are maintained on wooden pallets instead of adequate secondary containment. In addition, the 55-gallon drums are not sound; they are rusting and deteriorating.

This issue may result in an increased threat to life, health and safety, and gives the appearance that SYCRCC has not implemented and maintained an effective IIPP.

The CCR, Title 8, Section 5194 HCP, states in part, “Department heads shall monitor daily compliance with this procedure in the areas of their responsibility . . . Each area supervisor shall ensure that every person required to work with or use hazardous, toxic, volatile substances is appropriately trained.” CCR Title 15, 3303 (b), states in part “Institution heads shall maintain procedures for controlling the following safety and security hazards within the facility: Control of harmful physical agents and toxic or hazardous substances.” CCR, Title 15 sub-chapter 5. Article 1 3380(C), “Subject to the approval of the Wardens, Superintendents and parole region administrators will establish such operational plans and procedures as are required for implementation of regulations and as may otherwise be required for their respective operations . . .such procedures will apply only to the inmates, parolees, and personnel under the administrator.”

Recommendation

Comply with the CCR, Title 8, 15.

B. Injury and Illness Prevention Program

Codes of Safe Practices and Hazard Evaluations are not always developed and updated. Staff is not supplied with access to current hazard information pertinent to their work assignments. For example, a code of safe Practices and Hazard Evaluations has not been developed for Plant Operations, (i.e. each specific shop).

SYCRCC IIPP, dated January 2002, Page 3, Supervisors Responsibilities, states, "The supervisor has full authority to enforce provisions of the safety policy to keep losses at an absolute minimum. Each supervisor shall: - Develop and implement policies and procedures related to area specific work hazards."

The CCR, Title 8, section 3203 (D) will be adhered to, including: "Maintenance of all written documents for five years. Other forms of employer-to-employee communications on safety topics include specific posters, letters, meetings, etc... Local procedures include but are limited to Code of Safe Practices and other job-specific hazards . . ." Reference: CCR, Title 8, Sections 1669 through 1672.

Recommendation

Maintain the IIPP program.

C. Respiratory Program

Plant Operations does not have a written Respiratory Program. In addition, there is not a suitably trained program administrator in accordance with the CCR, Title, 8, Section 5144 and the GISO.

DJJ is not maintaining an injury and illness free workplace.

CCR, Title 8, Section 5144 and Subchapter 7. General Industry Safety Orders Group 16. Control of Hazardous Substances Article 107. Dusts, Fumes, Mists, Vapors and Gases (c) Respiratory protection program. This subsection requires the employer to develop and implement a written respiratory protection program with required worksite-specific procedures and elements for required respirator use. The program must be administered by a suitably trained program administrator. In addition, certain program elements may be required for voluntary use to prevent potential hazards associated with the use of the respirator. The Small Entity Compliance Guide contains criteria for the selection of a program administrator and a sample program that meets the requirements of this subsection.

Recommendation

Comply with the California Code of Regulations.

D. Confined Space Program

A formalized Confined Space Program has not been established, developed, and implemented. The written program shall be available for inspection by employees and their authorized representatives.

Employees are at risk of death, incapacitation, and impairment of ability to self-rescue.

CCR, Title 8, Article 108 5157(F), c) General requirements. 1) The employer shall evaluate the workplace to determine if any spaces are permit-required confined spaces. Note: Proper application of the decision flow chart in Appendix A would facilitate compliance with this requirement. 2) If the workplace contains permit spaces, the employer shall inform exposed employees and other employees performing work in the area, by posting danger signs or by any other equally effective means, of the existence, location of and the danger posed by the permit spaces. Note: A sign reading "DANGER -- PERMIT-REQUIRED CONFINED SPACE, DO NOT ENTER" or using other similar language would satisfy the requirement for a sign. 3) If the employer decides that its employees and other employees performing work in the area will not enter permit spaces, the employer shall take effective measures to prevent all such employees from entering the permit spaces and shall comply with subsections (c)(1), (c)(2), (c)(6), and (c)(8). (4) If the employer decides that its employees will enter permit spaces, the employer shall develop and implement a written permit space program that complies with this section. The written program shall be available for inspection by employees and their authorized representatives.

Recommendation

Provide documented training and update as required to conform to Industrial Safety Orders. Adopt a formalized Confined Space Program.

E. Emergency Equipment

The emergency eye wash stations located at the Plant Operations trades shop are not maintained appropriately. The AB noticed that the eyewash station logs had not been completed since April 2007.

These issues may result in an increased threat to life, health, and safety.

The CCR, Title 8, Section 5162(a), which states in part: “Plumbed eyewash equipment should be activated weekly to flush the line and to verify proper operation.” The American National Standards Institute (ANSI) Z358.1-1990 recommends that a written log be maintained to verify its operation. This condition does not meet minimum standards in case an emergency results and flushing of the eye is required.

Recommendation

Comply with the CCR, Title 8, and ANSI recommendations.

F. Backflows

There are deficiencies related to Cross Connection Program (i.e. Backflow devices). Backflow prevention assembly-testers are contracted with Aquatech Backflow Services, Inc., which performs routine PM test of backflow devices installed throughout the institution. The AB noted the following deficiencies regarding the cross-connection program: There is no master listing, locations of backflows could not be determined, there is no published cross connection schedule for 2008, and backflow devices are not tested annually.

This condition results in difficulty determining whether backflow tests have been performed

The CA Plumbing Code (CPC) 603.3.2, states in part: "The premise owner or responsible party shall have the backflow prevention assembly tested by a certified backflow assembly tester at the time of installation, repair, or relocation and at least on an annual schedule thereafter or more often when required. California Department of Health Services (DHS) Drinking Water and Environmental Management Division recommends that test results should be kept on file in a central location.

Recommendation

Create a master listing or use plot plans to identify all locations and devices. Test backflows on an annual basis. Continuous education of staff should be encouraged.

G. Pest Control

There are deficiencies related to pest/vector control. For example, there are no local OP's; insect and rodent activity is prevalent in the main kitchen. Doors and gates are not modified to be vermin proof. This was noted in the DHS EHS Survey 2006.

These conditions show ineffective pest/vector control.

CCR, Title 15, Subchapter 5, Article 1, 3380(c), Subject to the approval of the Wardens, Superintendents and parole Regional Administrators will establish such operational plans and procedures as are required for implementation of regulations and as may otherwise be required for their respective operations . . . Such procedures will apply only to the inmates, parolees, and personnel under the administrator".

Bargaining Unit 1 Agreement states: "Whenever a department utilizes a pest control chemical in a state owned or managed building/grounds, the department will provide at least forty-eight hours notice prior to application of the chemical, unless an infestation occurs which requires immediate action. Notices will be posted in the lobby building and will be disseminated to building tenant contacts."

Recommendation

Develop and implement written OP in accordance with the CCR, Title 15 and maintain compliance with DHS EHS recommendations.

H. Safety Meetings (tailgates)

Safety meetings (tailgates) are not conducted for each maintenance section at least every ten days and written minutes taken. The AB requested and did not receive documented safety meetings (tailgates) in accordance with the §CCR, Title 8.

Plant operations is not implementing and maintaining an effective IIPP.

CCR, Title 8, Article 3 section 8406(e) IIPP that states in part: "Supervisory personnel shall conduct "toolbox" or "tailgate" safety meetings with their crews at least weekly on the job to emphasize safety. A record of such meetings shall be kept, stating the meeting date, time, place, supervisory personnel present subjects discussed and corrective action taken, if any, and maintained for inspection.

Recommendation

Adhere to the CCR, Title 8.

III. FINES AND PENALTIES

A. Emergency Generators

Documentation of testing of the emergency generators is not in accordance with SYCRCC's maintenance schedule. In addition,

- There are no local procedures establishing standardized procedures and or direction for the testing and maintenance of emergency generators.
- SYCRCC has completed only 4 of the 14 scheduled maintenance tasks of the calendar year.
- Current operating permits requested by the AB were not provided by Plant Operations in order to verify if SYCRCC meets the conditions to operate.

In case of an emergency, the alternate electrical supply may fail. In addition, this condition makes it difficult to determine and validate that emergency generators are tested timely.

CCR Title 15, Subchapter 5 Article 1, 3380(c), Subject to the approval of the Wardens, Superintendents and parole Region Administrators will establish such operational plans and procedures as are required for implementation of regulations and as may otherwise be required for their respective operations . . . Such procedures will apply only to the inmates, parolees, and personnel under the administrator."

Recommendation

Comply with the CCR, Title 15.

IV. LATE DETECTION AND ADDITIONAL WORKLOAD

A. Preventive Maintenance

There are deficiencies related to performing PM. A written PM Plan has not been developed and implemented. The AB could not locate nor was the AB provided historical asset data on the facility's major systems listed below:

Mechanical Equipment

Heating/ventilating air handlers
Supply and return air fans
Air conditioning systems (compressors, condensers, coils and fans)
Cooling towers
Package air conditioning units
Unit ventilators and fan coil-units
Circulating pumps
Condensate return pumps
Lift and sump pumps
Unit pumps
Steam/hot water converters
Domestic water heaters
Air compressors
Vacuum pumps
Refrigeration
Boilers
Water Treatment systems

Electrical Equipment

Transformers
Switchgear
Motor control centers
Panel Boards (power, lighting)
Motor starters
Motors (as part of other units)
Emergency generators
Communication equipment
Alarm systems

These conditions decrease efficiency, increases downtime, and results in additional cost due to repairs.

Departmental Plant Operations Maintenance Procedures Manual (DPOMPM), I-A states in part, "Wardens/Superintendents are responsible for the development and implementation of a written preventive maintenance plan based on the guideline provided by Facilities Maintenance . . . Overall responsibility for the operation of this procedure shall be with the Correctional Administrator, Business Services, with functional responsibility delegated to the Chief of Plant Operations . . ."

The CCR, Title 15 sub-chapter 5 Article 1 3380(C), states in part, "Subject to the approval of the Wardens, Superintendents and parole region administrators will establish such operational plans and procedures as are required for implementation of regulations and as may otherwise be required for their respective operations . . . such procedures will apply only to the inmates, parolees, and personnel under the administrator."

Recommendation

Establish and document the systematic maintenance of all major institutional facilities and equipment.

B. Work Order System

SYCRCC has not established an approved OP for the work order system (work request and work orders) that affects the entire institution. The local operating procedure should establish guidelines for an orderly and standard method of processing and accomplishing the services requested of the Plant Operations. For example:

- The work order does not contain a date-completed and a completed by field.
- Supervisors are not approving work orders.
- Parts and materials are not listed on the work orders.
- A priority system has not been established.

There is no standard method of processing services requested of Plant Operations.

CCR, Title 15 sub-chapter 5. Article 1 3380(C), "Subject to the approval of the Wardens, Superintendents and parole region administrators will establish such operational plans and procedures as are required for implementation of regulations and as may otherwise be required for their respective operations . . .such procedures will apply only to the inmates, parolees, and personnel under the administrator."

Recommendation

Create and maintain a viable work request and work order procedure.

C. Operational Reporting

Operational reporting is not used as an effective management tool. Line supervisors do not adequately monitor and act upon weaknesses in a timely manner. The AB noted the following:

- The total hours used to maintain the physical plant is not documented.
- An operational maintenance report has not been completed or forwarded to management for decision-making.
- Priorities are not established in accordance to departmental guidelines.
- The CPOI or his/her designee does not inspect and document inspections on a regular basis. Examples include a hazard checklist for grounds and a hazard checklist for buildings.

- The CPOI or key plant staff is not assigned to a facility wide committee that has an impact on maintenance and other plant responsibilities such as a space utilization committee.

This issue may result in inadequate reports provided to institutional management and Central Office Maintenance Unit.

CCR Title 15 1280, states, "The facility administrator shall develop written policies and procedures for the maintenance of an acceptable level of cleanliness, repair and safety throughout the facility. Such a plan shall provide for a regular schedule of house keeping task and inspections to identify and correct unsanitary or unsafe conditions or work practices which may be found." SYRCC IIPP, states, "Safety inspections of all work areas are documented, at least monthly…The supervisor of each work area will be responsible for seeing that all unsafe conditions are corrected."

Recommendation

Produce reports, inspect facility, track, monitor plant operations activities, and review reports to determine whether they accurately reflect Plant Operations activities.

V. POLICIES AND PROCEDURES

A. POPM

The POPM is not maintained. For example, the POPM does not promulgate current and/or applicable OP that are relative to the daily operations of Plant Operations activities. The AB noted the following:

- There is no mission statement outlining the goals and objectives of the Plant Operations.
- There are no Tool Control Procedures that have been approved by the Superintendent.
- There is no procedure outlining the storage, use, and disposal of toxic materials.
- There is no procedure for lock-out tag-out.
- There is no PM section. Etc…

There is difficulty in identifying current OP; processes may not be standardized and may result in a vulnerable control system. In addition, lack of policy and procedures may make training difficult.

SAM, Section, 20050 states in part, "Experience has indicated that the existence of the following danger signal will usually indicate a poorly maintained and vulnerable control system . . . Policy and procedural or operational manuals are either not currently maintained or are non-existent."

The CCR, Title 15 sub-chapter 5 Article 1 3380(C), states in part “Subject to the approval of the Wardens, Superintendents and parole region administrators will establish such operational plans and procedures as are required for implementation of regulations and as may otherwise be required for their respective operations . . . such procedures will apply only to the inmates, parolees, and personnel under the administrator.”

Recommendation

Maintain a current POPM.

OFFICE OF AUDITS AND COMPLIANCE

AUDITS BRANCH

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER AND CLINIC

GLOSSARY

AB	Audits Branch
CAP	Corrective Action Plan
CCR	California Code of Regulations
CDCR	California Department of Corrections and Rehabilitation
CPC	California Plumbing Code
CPO	Chief of Plant Operations
DJJ	Division of Juvenile Justice
DHS	Department of Health Services
DPOMPM	Departmental Plant Operations Maintenance Procedures Manual
EHS	Environmental Health Survey
I&C	Institutions and Camps
IIPP	Injury and Illness Prevention Program
OAC	Office of Audits and Compliance
OP	Operational Procedure
PM	Preventive Maintenance
POPM	Plant Operations Procedures Manual
SAM	State Administrative Manual
YAM	Youth Authority Manual

COMPLIANCE PEER REVIEW

SOUTHERN YOUTH CORRECTIONAL RECEPTION CENTER AND CLINIC

Prepared by:

California Department of Corrections and Rehabilitation
Office of Audits and Compliance

Preliminary Report

July 2008

USE OF FORCE

Division of Juvenile Justice, Temporary Departmental Order #06-73, Sections 2080-2107 - Use of Force

Office of Audits and Compliance Staff
Gil DeLyon, Captain
Nemecio Ortiz Jr., Lieutenant

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EXECUTIVE SUMMARY

The Office of Audits and Compliance, Compliance/Peer Review Branch (CPRB) reviewed the Division of Juvenile Justice (DJJ), Temporary Departmental Order (TDO) 06-73, Sections 2080 through 2107, to determine whether the Southern Youth Correctional Reception Center and Clinic (SYCRCC) is in compliance with the policy that identifies peace officer responsibilities for applying force, reporting force, and reporting excessive and/or unnecessary force.

The review period for the Institutional Force Review Committee (IFRC) reports was August through November 2007. The CPRB identified a sample of 116 IFRC reports, as a result, provided a critical analysis of 10 percent of the reports to be included in the review. The review period for staff Use of Force (UOF) inquiries was January 1 through December 31, 2007. During this period, the CPRB determined that SYCRCC does not maintain a Superintendent's Inquiry/Grievance Incident database to track staff UOF inquiries and departmental inquiry timeframes. The findings are as follows:

The CPRB determined that SYCRCC is not in compliance with TDO 06-73, Sections 2085, 2102, and 2107.

- SYCRCC does not maintain a staff inquiry database.
- The IFRC does not consistently meet on a monthly basis.
- Time frames for UOF packets at the IFRC level are not being completed within departmental time frames.

BACKGROUND

The CPRB met with the DJJ on January 8, 2008, to discuss areas of high risk. UOF was identified as a high risk area, due to both past litigation and court mandates. Therefore, based on risk factor, the CPRB determined that UOF would be a topic of review. The review will help to ensure that all time frames are met and the UOF reports are accurately documented.

The specific objectives of the review were to determine whether:

- UOF is reviewed at a supervisory and managerial level, and the IFRC is meeting on a monthly basis. (TDO 06-73, Section 2085.)

- Time frames have been met regarding all applicable reports, clarifications, and forms pertaining to the UOF report package. (TDO 06-73, Section 2102.)

    a. Captain/Major – Normally within 2 business days of receipt.

    b. Superintendent - Normally within 2 business days of receipt.

    c. IFRC – To review within 30 days.

    d. Departmental Force Review Committee.

    e. Bureau of Independent Review.

- The UOF reports are maintained in a database and the length of time the reports are retained. (TDO 06-73, Section 2106.)

- All inquiries regarding allegations of excessive or unnecessary force are assessed (no action needed, conduct an inquiry, or recommend a formal Internal Affairs investigation), and the reports are completed within the required time frames. Additionally, when an inquiry is not concluded in 30-days, the superintendent/site administrator shall request a 30-day extension through the chain of command to the Director of the Division of Juvenile Facilities. (TDO 06-73, Section 2107.)

FINDINGS AND RECOMMENDATIONS

Finding I: SYCRCC does not maintain a staff inquiry database.

The CPRB conducted interviews with management and staff to determine whether SYCRCC maintains a database for tracking Staff Inquiries/Grievances concerning the reported UOF and/or allegations of force by staff on wards.

The CPRB determined that SYCRCC does not maintain a Superintendent's Inquiry/Grievance Incident database. Furthermore, SYCRCC was not able to provide hardcopy records of completed inquiries. The CPRB was able to locate four incomplete staff inquiry records for the review period, of which two were related to force, but was unable to determine what action, if any, was carried out by the facility.

SYCRCC attributed the deficiency to both a training issue and miscommunication between the Superintendent's office and the Health and Safety/Grievance Coordinator position. The facility stated that additional training would be provided, in order to resolve the inquiry tracking issue.

Criteria:

TDO# 06-73, Section 2107, states in part: "The superintendent/site administrator shall determine whether the reported incident and/or situation did occur and what action is required; e.g. no action needed, conduct an inquiry, or recommend a formal Internal Affairs Investigation,"

"All inquiries shall be completed within 30 working days of the superintendent's review of the complaint/report of misconduct," and

"If and when an inquiry is not concluded in 30-days, the superintendent/site administrator shall request a 30-day Inquiry Time Extension through the chain of command to the Director of the Division of Juvenile Facilities."

Recommendation(s):

Initiate a database system to track and account for Staff Inquiry/Grievance incidents.

Assign staff to track time frames for staff inquiries and file completed hardcopy records (inquiries, grievances, supporting documentation).

Provide training for staff regarding staff inquiries, grievances, and departmental time frames.

Finding II: The IFRC does not consistently meet on a monthly basis.

The CPRB interviewed management and staff to determine whether SYCRCC conducts monthly IFRC meetings. The CPRB determined that the facility does not consistently meet on a monthly basis. According to SYCRCC, due to the lack of UOF incidents at the facility, the IFRC monthly meetings are occasionally postponed to the following month.

Criteria:

TDO# 06-73, Section 2085, states in part: "All UOF shall be reviewed at a supervisory and managerial level" and "On at least a monthly basis, the IFRC shall meet to review all completed UOF incidents after critique by area managers."

Recommendation(s):

IFRC meetings should be held on a monthly basis and/or receive a waiver from DJJ Headquarters.

Provide training for staff regarding IFRC UOF incident reviews and departmental time frames.

Finding III: Time frames for UOF packets at the IFRC level are not being completed within departmental time frames.

The CPRB conducted interviews with management and staff, and reviewed the IFRC UOF records to determine whether SYCRCC is completing UOF packets within departmental time frames. During the period of August through November 2007, there were 116 IFRC UOF records. The CPRB reviewed 10 percent, for a total of 12 records.

Of the 12 UOF packets at the IFRC level, 8 (67 percent) were not completed within departmental time frames.

Due to the lack of UOF incidents, SYCRCC may reschedule the monthly IFRC meeting to the subsequent month. This is consistent with Finding II, which states the IFRC does not meet on a regular basis. Consequently, the IFRC packets are not completed within the 30-day timeframe.

Criteria:

TDO# 06-73, Section 2085, states in part: "All UOF shall be reviewed at a supervisory and managerial level" and "On at least a monthly basis, the IFRC shall meet to review all completed UOF incidents after critique by area managers."

TDO# 06-73, Section 2102, states in part: “Chief of Security – Review the incident report package normally within 2 days;” and “Superintendent - Review the incident report package normally within 2 days.”

Recommendation(s):

IFRC meetings should be conducted on a monthly basis and/or receive a waiver from DJJ Headquarters.

Provide training for staff regarding IFRC UOF incident reviews and departmental time frames.

Review of Security Operations

Southern Youth Correctional Reception Center and Clinic

GLOSSARY

CPRB	Compliance/Peer Review Branch
DJJ	Division of Juvenile Justice
IFRC	Institutional Force Review Committee
SYCRCC	Southern Youth Correctional Reception Center and Clinic
TDO	Temporary Departmental Order
UOF	Use of Force